APPENDICES

RFP-MQD-2011-003

Appendix A

Written Questions Format
QUEST RFP

Applicant Name	Date Submitted	Question #	RFP Section #	RFP Page #	Paragraph #	Question

STATE OF HAWAII

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: _____

RFP NUMBER: _____

RFP TITLE: _____

Check one:

☐ Initial Proposal Application

☐ Final Revised Proposal (Completed Items _____ - _____ only)

1. APPLICANT INFORMATION

Legal Name:

Doing Business As:

Street Address:

Mailing Address:

Contact person for matters involving this application:
Name:

Title:

Phone Number:

Fax Number:

e-mail:

2. BUSINESS INFORMATION

Type of Business Entity *(check one)*:

☐ Non-Profit Corporation ☐ Limited Liability Company ☐ Sole Proprietorship

☐ For-Profit Corporation ☐ Partnership

If applicable, state of incorporation and date incorporated:

State: Date:

3. PROPOSAL INFORMATION

Geographic area(s):

Target group(s):

4. FUNDING REQUEST

FY _____ _____ FY _____ _____

FY _____ _____ FY _____ _____

FY _____ _____ FY _____ _____

Grand Total _____

I certify that the information provided above is to the best of my knowledge true and correct.

_____ _____

Authorized Representative Signature *Date Signed*

_____

Name and Title

SPO-H 200 (Rev.9/06)

APPENDIX C
GAIN SHARE PROGRAM

Objective of the Program: The State is implementing a gain share program to assure that the capitation payments made to each health do not include profits beyond set targets. The gain share program shall be applied when profits exceed the set threshold for a health plan or the medical loss ratio is lower than the set limit.

Conceptual Framework: Under the gain share program, the DHS shall share in a difference between the capitated revenues and the actual costs experienced by the health plans. Six (6) months following the end of the calendar year (by June 30), using the financial reports provided by the participating health plans, a simple profit and loss statement shall be developed for the health services portion of the QUEST Programs. The health care services portion or medical loss ratio (MLR) of the capitation revenues is assumed to be no less than 88%. The health plan shall forfeit any percentage of capitation payments for any MLR less than 88%. DHS shall not pay the health plan additionally for any MLR in excess of 88%.

After the adjustment for lower MLR, if necessary, the second part of the gain share calculation involves the calculation of profits from capitation revenue. Profits are considered anything other than health care service expenses (or medical losses) that are greater than the 88% identified above and administrative expenses. The health plan shall share in profits between 2% and 4% and returning to the state profits in excess of 4%. Note that revenue from the P4P program is not counted as revenue or profits for purposes of this calculation.

Excluding remittance for MLR less than 88%, health plans experiencing an actual gain above the 2% corridor only shall be required to reimburse the State. If there is a gain exceeding 2%, the DHS shall share equally with the health plan in the gain between 2% and 4%. The DHS shall recover all gains exceeding 4%. Therefore, the maximum net gain is 3%. For example, if a health plan has a gain of 4.5%, for the 2.5% difference beyond the 2% corridor, the first 2% difference shall be shared equally between the DHS and the health plan. The second 0.5% shall be returned to the State.

* The following definitions apply:

Total Revenue is the sum of all capitation payments made to each health plan during the fiscal year.

Medical Loss Ratio is the net health care expenses divided by the sum of the total revenue.

Profits are calculated as the net income or contributions to surplus after deducting the following from capitation revenue: medical expenses, administration and the minimum MLR settlement as described in this section.

The expenses shall be taken from the financial reports provided by the health plans for the year ended December 31. DHS recognizes that the financial reports are due within 45 days from the end of the reporting period and that some data may not be available at the time the reports are submitted. Therefore, prior to compiling the statement for the gain share program, the plans shall be requested to update their prior year's report for any adjustments. The report shall be due to the DHS by July 15.

Examples: The following examples illustrate how the Gain Share Program would be applied to the health plans

Example #1
Health Plan with 85% MLR, 9.5% Administration

			Gain Sharing Adjustment	
			Plan Share	**DHS Share**
Minimum MLR		88.00%		
Actual MLR	(1)	85.00%		
MLR Settlement	(2)	3.00%	N/A	3.00%
Plan Administration		9.50%		
Profit/Surplus	(3)	2.50%		
Gain up to 2%	(4)		2.00%	N/A
Gain 2% to 4%	(5)		0.25%	0.25%
Gain over 4%	(6)		N/A	0.00%

(1) Actual MLR = Medical Expenses / Capitation Revenue

(2) Minimum MLR Settlement = Greater of (Minimum MLR - Actual MLR) or 0.00%

(3) Profit/Surplus = 100% - Actual MLR – MLR Settlement – Administration Percentage

(4) Plan keeps 100% of first 2% of profit/surplus

(5) Plan and DHS share equally profit/surplus between 2% and 4%

(6) DHS collects profit/surplus in excess of 4%

Example #2
Health Plan with 88% MLR, 7.5% Administration

			Gain Sharing Adjustment	
			Plan Share	DHS Share
Minimum MLR		88.00%		
Actual MLR	(1)	88.00%		
MLR Settlement	(2)	0.00%	N/A	0.00%
Plan Administration		7.50%		
Profit/Surplus	(3)	4.50%		
Gain up to 2%	(4)		2.00%	N/A
Gain 2% to 4%	(5)		1.00%	1.00%
Gain over 4%	(6)		N/A	0.50%

Example #3
Health Plan with 90% MLR, 9.5% Administration

			Gain Sharing Adjustment	
			Plan Share	DHS Share
Minimum MLR		88.00%		
Actual MLR	(1)	90.00%		
MLR Settlement	(2)	0.00%	N/A	0.00%
Plan Administration		9.50%		
Profit/Surplus	(3)	0.50%		
Gain up to 2%	(4)		0.50%	N/A
Gain 2% to 4%	(5)		0.00%	0.00%
Gain over 4%	(6)		N/A	0.00%

(1) Actual MLR = Medical Expenses / Capitation Revenue

(2) Minimum MLR Settlement = Greater of (Minimum MLR - Actual MLR) or 0.00%

(3) Profit/Surplus = 100% - Actual MLR – MLR Settlement – Administration Percentage

(4) Plan keeps 100% of first 2% of profit/surplus

(5) Plan and DHS share equally profit/surplus between 2% and 4%

(6) DHS collects profit/surplus in excess of 4%

APPENDIX D
DENTAL PROCEDURES WHICH
ARE THE RESPONSIBILITY OF THE HEALTH PLAN

HCPCS or CDT-5 Procedure Code*	Description
D/07340	Vestibuloplasty-ridge extension
D/07350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Tumors
D/07440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D/07441	Excision of malignant tumor – lesion diameter over 1.25 cm
	Removal of Cysts and Neoplasms
D/07450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D/07451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D0/7461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D/07465	Destruction of lesions by physical methods; electrosurgery, chemotherapy, cryotherapy or laser
	Excision of Bone Tissue
D/07471	Removal of lateral exostosis – mandible or maxilla
D/07472	Removal of torus palatinus
D/07473	Removal of torus mandibularis
D/07490	Radical resection of mandible or maxilla
	Surgical Incision
D/07511	Incision and drainage of abscess-intra oral soft-tissue-complicated
D/07520	Incision and drainage of abscess-extraoral soft tissue
D/07530	Removal of foreign body, skin, or subcutaneous areolar tissue
D/07540	Removal of reaction-producing foreign bodyies, musculoskeletal system
D/07550	Sequestrectomy for osteomyelitis
D/07560	Maxillary sinusotomy for removal of tooth fragment or foreign body
	Treatment of Fractures – Simple
D/07610	Maxilla – open reduction (teeth immobilized if present)
D/07620	Maxilla – closed reduction (teeth immobilized if present)
D/07630	Mandible – open reduction (teeth immobilized if present)
D/07640	Mandible closed reduction (teeth immobilized if present)

HCPS codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 Procedure Code*	Description
D/07650	Malar and/or zygomatic arch-open reduction
D/07660	Malar and/or zygomatic arch-closed reduction
D/07670	Aveolus – stabilization of teeth, open reduction, splinting
D/07680	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Treatment of fractures – Compound
D/07710	Maxilla – open reduction
D/07720	Maxilla – closed reduction
D/07730	Mandible – open reduction
D/07740	Mandible – closed reduction
D/07750	Malar and/or zygomatic arch-open reduction
D/07760	Malar and/or zygomatic arch-closed reduction
D/07770	Alveolus – complicated reduction with fixation and multiple surgical approaches
D/07780	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions
D/07810	Open reduction of dislocation
D/07820	Closed reduction of dislocation
D/07830	Manipulation under anesthesia
D/07840	Condylectomy
D/07850	Surgical disectomy, with/without implant
D/07852	Disc repair
D/07854	Synovectomy
D/07856	Myotomy
D/07858	Joint reconstruction
D/07860	Arthrotomy
D/07870	Arthrocentesis
D/07872	Arthroscopy – diagnosis, with or without biopsy
D/07873	Arthroscopy – surgical: lavage and lysis of adhesions
D/07874	Arthroscopy – surgical: disc repositioning and stabilization
D/07875	Arthroscopy – surgical: synovectomy
D/07876	Arthroscopy – surgical: discectomy
D/07877	Arthroscopy – surgical: dibridement
D/07880	Occlusal – orthotic device, by report
	Other Oral Surgery – Repair of Traumatic Wounds
D/07910	Suture of recent small wounds up to 5 cm
D/07911	Complicated suture up to 5 cm
D/07912	Complicated suture over 5 cm

HCPS codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

HCPCS or CDT-5 Procedure Code*	Description
D/07920	Skin grafts (identify defect covered, location and type of graft)
	Other Repair Procedures
D/07940	Osteoplasty for orthognathic deformities
D/07941	Osteotomy – mandibular rami
D/07943	Osteotomy mandibular rami with bone graft; include obtaining the graft
D/07944	Osteotomy, segmented or subapical, per sextant or quadrant
D/07945	Osteotomy, body of mandible
D/07946	Le Fort I (maxilla –total)
D/07947	Le For I (maxilla – segmented)
D/07948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft)
D/07949	Le Fort II or Le Fort III – with bone graft
D/07950	Osseous, osteoperiosteal, periosteal, or cartilage graft of the mandible – autogenous or nonautogenous
D/07955	Repair of maxillofacial soft and hard tissue defects
D/07980	Sialolithotomy
D/07981	Excision of salivary gland, by report
D/07982	Closure of salivary fistula
D/07990	Emergency tracheotomy
D/07991	Coronoidectomy
D/07995	Synthetic graft – mandible or facial bones, by report
D/07996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report
D/07997	Appliance removal (not by dentist who replaced appliance), includes removal of archbar
D/07999	Unspecified oral surgery procedure, by report
	Adjunctive General Services
D/09220	General anesthesia – first 30 minutes (limitation: nitrous oxide for unruly children or highly apprehensive adults; attach report or note)
D/09221	General anesthesia – each additional 15 minutes
D/094220	Hospital calls (limitation: confinement must be approved; only under physician's request; no routine or follow-up visits)

HCPS codes will be billed with the "zero" as the first character. CDT-5 codes will be billed with the "D" as the first character.

SEBD SERVICES

The benefits of the **Support for Emotional and Behavioral Development** (SEBD) program include intensive mental health services provided through the State of Hawaii's Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD).

WHO IS ELIGIBLE?

A child, youth or adolescent who meets the following:

- Is age 3 through 20 years of age; and
- Has Hawaii QUEST or Medicaid Fee-For-Service insurance; and
- Has significant problems* with different areas of life such as home and school; and
- Has a qualifying primary DSM-IV Axis I diagnosis.

* Assessments and other information provided would be used to determine the extent of a child's emotional and behavioral needs.

WHAT ARE THE SERVICES?

Services may include any of the services listed below (and more) that are appropriate to the needs of the child.

- 24-Hour Crisis Mobile Outreach
- Intensive Case Management
- Psychosexual Assessment
- Intensive Home & Community Based Intervention
- Functional Family Therapy
- Multidimensional Treatment Foster Care
- Multisystemic Therapy
- Therapeutic Foster Home
- Respite Home
- Therapeutic Group Home
- Community Based Residential Programs
- Hospital Based Residential Services

WHO PROVIDES THE SERVICES?

The mental health professionals at CAMHD's conveniently located Family Guidance Centers will coordinate the intensive mental health services for the child.

WHERE DO I BEGIN?

Answer the following questions:

1. Would you like help with your child's emotional or behavioral problems?
2. Are you willing to have your child tested for these problems?
3. Is your child receiving Hawaii QUEST or Medicaid Fee-For-Service health insurance?

If you answered "YES" to all of the questions above, call the nearest Family Guidance Center and ask to speak with an SEBD Intake Coordinator. See the list at the back of this brochure.

Tell the Intake Coordinator that you would like to make an appointment to see if your child is able to get SEBD services.

WHO DECIDES THE ELIGIBILITY FOR SERVICES?

CAMHD's mental health professionals decide eligibility based upon information gathered.

FAMILY GUIDANCE CENTERS

Oahu

Central Oahu (Pearl City)
860 Fourth St 2nd Flr
Pearl City, HI 96782
808 453-5900
(Fax) 453-5940

Central Oahu (Kaneohe)
45-691 Keaahala Rd
Kaneohe, HI 96744
808 233-3770
(Fax) 233-5659

Leeward Oahu
601 Kamokila Blvd Suite 355
Kapolei, HI 96707
808 692-7700
(Fax) 692-7712

Honolulu
3627 Kilauea Ave Rm 401
Honolulu, HI 96816
808 733-9393
(Fax) 733-9377

Family Court Liaison Branch
42-477 Kalanianaole Hwy
Kailua, HI 96734
808 266-9922
(Fax) 266-9933

Maui

Maui (Wailuku)
270 Waiehu Beach Rd, Ste 213
Wailuku, HI 96793
808 243-1252
(Fax) 243-1254

Maui ((Lahaina)
1830 Honoapiilani Hwy
Lahaina, HI 96761
808 662-4045
(Fax) 661-5450

Molokai

65 Makaena Place
Kaunakakai, HI 96748
808 553-5067
(Fax) 553-9859

Lanai

c/o Lanai High & Elem School
555 Fraser Avenue
Lanai City, HI 96763
808 565-7915
(Fax) 565-7904

Hawaii

Hawaii (Hilo)
88 Kanoelehua, Ste A-204
Hilo, Hawaii 96720
808 933-0610
(Fax) 933-0558

Hawaii (Kona)
81-980 Haleki'i St Rm 101
Kealakekua, HI 96750
808 322-1541
(Fax) 322-1543

Hawaii (Waimea)
65-1230 Mamalahoa Hwy Suite A-11
Kamuela, HI 96743
808 887-8100
(Fax) 887-8113

Kauai

3-3204 Kuhio Hwy, Rm 104
Lihue, HI 96766
808 274-3883
(Fax) 274-3889

SEBD Behavioral Plan Assistant
(808) 733-9815 or
CAMHD's toll free number 1-800-294-5282
and ask for the SEBD BHP Office

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVE RM 101
HONOLULU HAWAII 96816

E-2

Rev 10/10 (A7809)
For general distribution.

DO YOU KNOW A CHILD WITH EMOTIONAL AND BEHAVIORAL CHALLENGES?

SUPPORT FOR EMOTIONAL AND BEHAVIORAL DEVELOPMENT

FOR CHILDREN AND ADOLESCENTS WHO HAVE HAWAII QUEST OR MEDICAID FEE-FOR-SERVICE HEALTH PLANS

APPENDIX F
COVERED PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

The following is a listing of preventive services for which payments will be made by the health plan.

FOR ADULTS

The following are services for which payments will be made by the health plan as separate medical services, as components of separate medical services, or as components of the "evaluation and management" services rendered by the health plan's providers. The services and periodicity are adapted from the 1996 U.S. Preventive Services Task Force.

Screening

1. **Blood Pressure Measurement**
   Minimum: every single measurement, all ages and sexes
   Periodicity: every 2 years if normal
   (on basis of expert opinion) every 1 year or more frequently if abnormal

2. **Weight/Height Measurement**
   Minimum: all ages and sexes; single measurement
   Periodicity: (on basis of expert opinion) every 2 years

3. **Total Cholesterol Measurement**
   Minimum: females age 45-65; single measurement
   Males 35-65; single measurement
   Periodicity: every 5 years
   (there is insufficient evidence to recommend cholesterol measurement in younger adults with high cardiovascular disease risk factors or in older adults, however recommendation for screening may be made on other grounds. See U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services, 2nd ed.* Baltimore: Wilkins & Wilkins, 1996)

4. **Breast Cancer Screening**
   Minimum: age 50 – 69 mammography alone or mammography and clinical breast exam (CBE)
   Periodicity: annual

   Minimum: age 40 – 49; although there is insufficient evidence to recommend either mammography alone or mammography and CBE, the American Cancer Society, the American College of OB/Gyn, and the American Academy of Family Physicians, recommend

mammography every 1-2 years and CBE every year. If done at this frequency, the health plan shall reimburse providers.

Minimum: age 70-72; although there is insufficient evidence to recommend mammography screening, the health plan shall reimburse providers for providing every 1-2 years

5. **Cervical Cancer Screening**
   Minimum: pap test and pelvic exam; all sexually active women or age 18-65
   Periodicity: annual, decreasing to every 3 years after 3 successive normal annual tests

   Since it may be difficult to assess accurately if there have been 3 successive normal annual tests, annual pap tests will be reimbursed by the health plan.

6. **Colorectal Cancer Screening**
   Minimum: age 50 or older; single sigmoidoscopy or annual fecal occult blood test (FOBT)
   Periodicity: annual FOBT, sigmoidoscopy at age 50 and then every 10 years

7. **Prostate Cancer Screening**
   Not recommended for routine screening.

   If screening is to be performed, digital rectal exam and prostate specific antigen (PSA) for age 50-70 is best evaluated approach but should be preceded by objective information about the potential benefits and harms of early detection.

8. **Rubella Serology or Vaccination History**
   Minimum: women of child bearing age

9. **Tuberculin Skin Testing**
   Minimum: the current methodology, schedule and priority (immigrants, TB contacts, food handlers, health care and school workers, etc.) established by the DOH

10. **Health Education and Counseling**
    a. Substance use, including alcohol
    b. Diet and exercise
    c. Injury prevention
    d. Sexual behavior
    e. Dental health
    f. Family violence
    g. Depression: there is insufficient evidence to recommend for or against the routine use of standardized questionnaires to screen for depression in asymptomatic patients
    h. Results and implications of screening listed above

Immunizations

1. Tetanus-diphtheria (Td) booster
2. Rubella (or evidence of immunity) for women of child-bearing age
3. Hepatitis B in high risk groups—household and sexual contacts of HBsAg positive person

Chemoprophylaxis

1. Multivitamin with folic acid – pregnant women and women actively trying to become pregnant
2. Counsel all peri and post menopausal women about the potential benefits and risk of hormone prophylaxis

FOR THE HIGH RISK POPULATION

Required preventive interventions are those provided for adults and listed above **and** the following:

Risk Factor	Intervention
Low-income; immigrants; alcoholics; TB contacts	PPD
Certain chronic medical conditions; institutionalized persons	PPD; pneumococcal vaccine; influenza vaccine
Health care/lab workers	PPD; hepatitis B and hepatitis A influenza vaccine
Family h/o skin cancer; fair skin	Avoid sun exposure
Blood product recipients	HIV screen; hepatitis B vaccine
Susceptible to measles, mumps or varicella	MMR; varicella vaccine
Previous pregnancy with neural tube defect	Folic acid 4.0 mg
Injection of street drug use	RPR/VDRL; PPD; HIV screen; hepatitis B & A vaccines
High risk sexual behavior	STD screens; hepatitis B & A vaccines

FOR PREGNANT WOMEN

The following are services for which the health plan must reimburse providers as separate medical services, components of separate medical services or as components of the maternity (vaginal/Cesarean section delivery; prenatal care; postpartum care) benefit.

1. **Prenatal Laboratory Screening Tests**
   Including voluntary HIV testing and counseling and tests for alpha-fetoprotein, alone or in combination with other tests to screen for neural tube anomalies and chromosomal anomalies such as Down's syndrome. Prenatal laboratory screening tests covered include testing for gestational diabetes, rubella, GC, Chlamydia, pap

smear, Hepatitis B, blood typing and RH, urinalysis, complete blood count, etc. as currently recommended by the American College of Obstetrics and Gynecology (ACOG).

2. **Prenatal Visits**
   Those meeting the periodicity and standards currently recommended by the ACOG.

3. **Health Education and Screening**
   For conditions which could make a pregnancy "high-risk" such as smoking, alcohol and other substance abuse, depression, inadequate diet, psychosocial problems, signs of premature labor, other medical conditions, etc. and appropriate referrals including WIC and mental health providers. Other health education such as fetal development, breastfeeding, labor and delivery.

4. **Diagnosis of Premature Labor**

5. **Diagnostic Amniocentesis, Diagnostic Ultrasound, Fetal Stress and Non-Stress Testing**

6. **Prenatal Vitamins Including Folic Acid**

7. **Hospital Stays**
   Up to 48 hours after vaginal delivery or 96 hours after Cesarean section delivery for health women with uncomplicated deliveries and postpartum stays following current guidelines of the American Academy of Pediatrics (AAP) or ACOG.

FOR CHILDREN

The following are services for which the health plan shall reimburse providers as separate medical services, as components of separate medical services, or as components of the EPSDT comprehensive evaluation.

1. **Newborn Screening**
   Includes newborn hearing assessment, newborn laboratory screening—phenylketonuria, hypothyroidism, and other metabolic diseases as specified by the Department of Health (DOH) and currently in effect

2. **Hospital Stays for Normal, Term, Healthy Newborns**
   Up to 48 hours after normal vaginal delivery or up to 96 hours after cesarean section delivery following current guidelines of the AAP and ACOG.

3. **Other Age Appropriate Laboratory Screening Tests**
   Includes those currently in effect as recommended by the AAP, the Centers for Disease Control (CDC), and/or required by the Centers for Medicare & Medicaid

Services (CMS) for Medicaid recipients (for example, hemoglobin/hematocrit, blood lead level).

4. **Screening to Assess Health Status**
Includes age appropriate general physical and mental health, growth, development, and nutritional status. The periodicity schedule follows the AAP's Guidelines for Health Supervision currently in effect. Included, but not limited to the following:

   a. Initial/interval health history
   b. Height/weight/head circumference
   c. Blood pressure
   d. Developmental assessment using the Denver Developmental Screening Test of Developmental Inventory (MCDI), or any other acceptable method for developmental screening
   e. Behavioral assessment (including screening for substance abuse for ages 12+)
   f. Vision testing
   g. Hearing/language testing; audiometry
   h. Physical examination

5. **Tuberculin Skin Testing**
Using the method recommended by the DOH, following a schedule recommended by the Hawaii Chapter, AAP.

6. **Immunizations**
Following the standards and schedule of the Advisory Committee on Immunization Practices (ACIP) and the DOH currently in effect.

7. **Age Appropriate Dental Referral and Oral Fluoride**

8. **Age Appropriate Health Education**
Includes education to child and/or parent including dietary counseling, injury prevention, child maturation/development, behavior management, dental care, sexuality, family violence, STD, HIV, pregnancy, and depression. Provisions for children aged 12 years and older to be able to discuss sensitive issues alone with the provider or designated staff.

Appendix G

Eligibility Diagnoses for Additional Behavioral Health Services for Adults

Mentally ill adults who are unstable and moderate-high risk are eligible for additional intensive services if the adult:

- Demonstrates the presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis (as found in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)) for the next twelve (12) months, and
- Meets at least one of the criteria demonstrating instability and/or functional impairment:
    - GAF < 50; or
    - Clinical records demonstrate that member is unstable under current treatment or plan or care; or
    - Requires protective services or intervention by housing/law enforcement officials.
- Members that do not meet the eligibility criteria, but still felt by the health plan's medical director that additional services are medically necessary for the member's health and safety, should be evaluated on a case by case basis for provisional eligibility.

Eligible Diagnoses:

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders- Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders- Depressive Disorders (296.24, 296.33, 296.34)

INSTRUCTIONS
DHS FORM 1147
Rev. 01/09
LEVEL OF CARE (LOC) EVALUATION

1. ***Check the appropriate box for the evaluation:*** Check type of request - initial, annual or other review, i.e. 3 month review to determine continued stay.

2. ***Patient Name***: Self-explanatory

3. ***Birthdate***: Self-explanatory

4. ***Sex***: Indicate whether the patient is "M" for male or "F" for female.

5. ***Medicare***: Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient's Medicare I.D. number, if eligible for either Part A or B.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***Present Address***: Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility.
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include Patients at a care home and nursing facility level of care.
   Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes Patients at a nursing facility level of care.
   Other: Check this box if the patient's present address is not listed above. Write in the description.

8. ***Medicaid Provider Number***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.

9. ***Attending Physician/Primary Care Provider (PCP)***: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

11. ***Referral Information***: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    A. **Source(s) of Information**: Identify the source(s) of patient information received.

    B. **Responsible Person**: Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.

    C. **Language**: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. ***Assessment Information***: Complete all sections.

    A. **Assessment Date**: Indicate the date of the most current assessment.

    B. **Assessor's Name, Title, Signature, Phone and Fax Numbers**: A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.

    Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. ***Requesting Level of Care***: Check service that is being requested. Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician verification form. *Hospice services in other settings do not require an 1147 form.*

Indicate the length of approval requested. Check one box.

14. ***Medical Necessity/Level of Care Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/PATIENT BACKGROUND INFORMATION

1. ***Name***: Self-explanatory

2. ***Birthdate***: Self-explanatory

3. ***Functional Status Related to Health Conditions***: Complete all sections.

I. **List significant current diagnosis(es)**: List the primary and secondary diagnosis(es) or medical conditions related to the patient's need for long-term care.

II. **Comatose**: If patient is comatose, check "Yes" box and go directly to Section XIV. If patient is not comatose, check "No" and complete rest of section.

III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming**: Select the description that best describes the patient's functioning.

Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.

XIV. **Total Points**: Add the points from each section to obtain total. Comatose patients are assigned 30 points.

XV. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than significant medications than available lines, attach orders or treatment sheet.

XVI. **Additional Information Concerning Patient's Functional Status**: Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.

XVII. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

If restorative therapy is being requested, attach the evaluation and treatment plan(s) AND indicate whether the patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XVIII. **Social Situation**:

A. **Person can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the atient is already in a home environment. If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

B. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

C. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

XIX. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the Patient's nursing requirements or social situation.

Physician Signature/PCP: Self-explanatory.

Electronic submittal of form(s) will be accepted with the box checked that the physician or the primary care provider has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician or primary care provider. The hard copy of the form(s) must be kept in the Patient's file.

Date: Indicate the date of the physician or Primary Care Provider's signature.
Physician's/PCP Name: Self-explanatory.

Filing Instructions: Mail, fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1440 Kapiolani Blvd., Suite 1110, Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE	6. MEDICAID ELIGIBLE?
			Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:	☐ Yes ID # _____ ☐ No Date Applied _____

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: _____

8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)

Phone : ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR/CONTACT PERSON): _____

MANAGED CARE PLAN NAME (IF APPLICABLE): _____

[ ] VIA FAX (Print Fax Number Below)
Phone ( )_____ Fax ( )_____ Email ( )_____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other _____

B. RESPONSIBLE PERSON
Name _____
Last First MI

Relationship _____

PHONE ( )_ FAX ( ) _____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI

Title _____

Signature _____ ☐ Hard copy signature on file.

PHONE: ( ) _____ FAX: ( ) _____
EMAIL: ( ) _____

13. REQUESTING LEVEL OF CARE

CHECK ONE BOX:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

14. MEDICAL NECESSITY / LEVEL OF CARE DETERMINATION – DO NOT COMPLETE

LEVEL OF CARE APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN AND END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months
[ ] 6 months [ ] 1 year
[ ] Other: _____

Comments: _____

DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1440 Kapiolani Blvd., Suite 1110 Honolulu, HI 96814
Phone: (808) 440-6000 Fax: (808) 440-6009

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. NAME (Last, First, Middle Initial)	2. BIRTHDATE

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

_____

SECONDARY: _____

_____

_____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XIV.**

III. VISION / HEARING / SPEECH:
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[1] b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[2] c. Individual has complete absence of: ☐ Hearing ☐ Vision ☐ Speech

IV. COMMUNICATION:
[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MEMORY:
[0] a. Normal or minimal impairment of memory.
[1] b. Problem with [ ] long-term or [ ] short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.)
[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive.
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, or in danger of self-inflicted harm or self-neglect.

VII. FEEDING/MEAL PREPARATION:
[0] a. Independent with or without an assistive device.
[1] b. Feeds self but needs help with meal preparation.
[2] c. Needs supervision or assistance with feeding.
[4] d. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:
[0] a. Independent with or without a device.
[2] b. Transfers with minimal /stand-by help of another person.
[3] c. Transfers with supervision and physical assistance of another person.
[4] d. Does not assist in transfer or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either mobile or unable to walk, no other selections can be made.)
[0] a. Independently mobile with or without device.
[1] b. Ambulates with or without device but unsteady / subject to falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one assist.
[4] e. Able to walk/be mobile with more than one assist.
[5] f. Unable to walk.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

XII. BATHING:
[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:
[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing, and grooming.

XIV. TOTAL POINTS:

Comatose = 30 points

Total Points Indicated: _____

XV. MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

XVI. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS:

_____

_____

_____

_____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
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Phone: (808) 440-6000 Fax: (808) 440-6009

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (PRINT Last, First, Middle Initial)	2. **BIRTHDATE**

XVII. SKILLED PROCEDURES: D = Daily Indicate number of times per day L = Less than once per day N = Not applicable / Never

D #	L √	N √	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	[ ]	[ ]	Tracheostomy care/suctioning in ventilator dependent person
___	[ ]	[ ]	Tracheostomy care/suctioning in non-ventilator dependent person
___	[ ]	[ ]	Nasopharngeal suctioning in persons with no tracheostomy
___	[ ]	[ ]	Total Parenteral Nutrition (TPN) {Specify number of hours per day): _____
___	[ ]	[ ]	Maintenance of peripheral/central IV lines
___	[ ]	[ ]	IV Therapy (Specify agent & frequency): _____
___	[ ]	[ ]	Decubitus ulcers (Stage III and above)
___	[ ]	[ ]	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed) _____
___	[ ]	[ ]	Wound care (Specify nature of wound and care prescribed) ☐ debridement ☐ irrigation ☐ packing ☐ wound vac. _____
___	[ ]	[ ]	Instillation of medications via indwelling urinary catheters (Specify agent): _____ _____
___	[ ]	[ ]	Intermittent urinary catheterization
___	[ ]	[ ]	IM/SQ Medications (Specify agent.) :_____
___	[ ]	[ ]	Difficulty with administration of oral medications (Explain): _____
___	[ ]	[ ]	Swallowing difficulties and/or choking
___	[ ]	[ ]	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? ☐ Yes ☐ No
___	[ ]	[ ]	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration (Specify reason person at risk for aspiration) _____
___	[ ]	[ ]	Initial phase of Oxygen therapy
___	[ ]	[ ]	Nebulizer treatment
___	[ ]	[ ]	Complicating problems of patients on [ ] renal dialysis, [ ] chemotherapy, [ ] radiation therapy, [ ] with orthopedic traction (Check problem(s) and describe) : _____
___	[ ]	[ ]	Behavioral problems related to neurological impairment (Describe): _____ _____
___	[ ]	[ ]	Other (Specify condition and describe nursing intervention): _____ _____
☐ Yes	☐ No		Therapeutic Diet (Describe): _____
☐ Yes	☐ No		Restorative Therapy (check therapy and submit/attach evaluation and treatment plan): ☐ PT ☐ OT ☐ Speech
☐ Yes	☐ No		The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XVIII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A
B. If person has a home; caregiving support system is willing to provide/continue care. ☐ Yes ☐ No
Caregiver requires assistance? ☐ Yes ☐ No
Assistance required by Caregiver: _____ _____

C. Caregiver name:
Name: _____ Relationship: _____
Last First MI
Address: _____ Phone: (___) _____ Fax (___) _____

XIX. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____
_____

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT.
PHYSICIAN'S SIGNATURE/PCP: _____
☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP. **DATE:** ___/___/___
Physician's/PCP Name (PRINT): _____

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Clinical Standards Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

January 8, 2010

MEMORANDUM

MEMO #
ADM-1003
ADMX-1003
[Replaces ACS-0709]

TO: Medicaid EPSDT Providers, QUEST and QExA Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH KF
Med-QUEST Division Administrator

SUBJECT: EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) UPDATE

The Med-QUEST Division (MQD) issues this memo to inform providers of the changes occurring to the EPSDT forms and procedures. For any questions and clarifications on the content of this memorandum, please contact the MQD Clinical Standards Office at 808-692-8121. We encourage you to share this memo with all office staff involved with the EPSDT visit and submittal of EPSDT claims.

SECTION A: Form Changes and New Online Tool
SECTION B: Requirements
SECTION C: Billing Procedures
APPENDIX 1: Billing Codes for Comprehensive EPSDT Exams
APPENDIX 2: Billing Codes for Catch-Up/Follow-Up EPSDT Exams

SECTION A: EPSDT Form Changes and New Online Tool

1) **Revised DHS 8015 and 8016.** The EPSDT form has been updated to align with the most current recommendations and guidelines and in response to input from providers in the community. Please refer to the attached DHS 8015 and 8016. Effective April 1, 2010, the previous versions will no longer be accepted. The DHS 8015A has been eliminated.

   DHS 8015 continues to serve the purpose of guiding providers through the required components of an EPSDT exam, improving the quality of exams, and through the data

collected, providing a better understanding of the health and health needs of our Medicaid clients.

DHS 8016 is used to document the completion of any screening(s) and/or immunization(s) that were attempted and not done during a comprehensive EPSDT screening visit, as well as to document any immunization or screening not captured on the 8015 or not associated with a comprehensive EPSDT screening visit.

Forms may be obtained by calling ACS at 808-952-5570. Neighbor Island providers may call 1-800-235-4378 to obtain additional forms. The instructions for completing the form appear in detail on the back of the DHS 8015/8016.

2) **Online EPSDT.** An electronic version of the EPSDT form is now available online at https://hawaii.directaccessehr.com. Currently, this is the pilot site for training purposes. Effective March 1, 2010, providers will be able to enter data for an EPSDT exam online and submit this electronically. The online EPSDT also provides a database of previous vaccines, screenings, referrals, and other information, and it will provide prompts and alerts for services that are due. Providers are strongly encouraged to use the online EPSDT tool.

   Assistance in accessing electronic EPSDT system and obtaining a passcode, call ACS at 1-877-222-3218. Once in the system, training in how to complete the electronic form can be obtained from any QUEST or QExA health plan. Providers may begin electronic submission effective March 1, 2010.

3) **Collaborative Health Plan Trainings.** The QUEST and QExA health plans will conduct training for providers on the revised DHS 8015/8016 and the online EPSDT tool starting in January 2010. For training purposes, one health plan may represent other health plans with whom the provider is contracted. Training for the online tool will be provided jointly with ACS.

SECTION B: EPSDT Requirements

1) Required elemements for the EPSDT exam follow CMS and AAP/Bright Futures guidelines. The health plans will be working with providers to ensure that an EPSDT visit paid at the increased EPSDT rate meets the requirements for that visit.

2) Elements for the complete visit should be reported in the DHS 8015 form and supported by documentation in the medical record, including:
   a. an initial or interval history
   b. measurements
   c. sensory screening
   d. developmental assessments, including autism, with validated screening tools
   e. TB risk assessments
   f. lead risk assessments
   g. psychosocial and behavioral assessments

h. alcohol and drug use assessment for adolescents
i. STI and cervical dysplasia screening as appropriate
j. dyslipidemia screening as appropriate
k. complete physical exam
l. age appropriate surveillance
m. immunizations
n. procedures such as hemoglobin and lead level as appropriate
o. referral to a dental home
p. referrals to state or specialty services
q. care coordination assistance if needed
r. age appropriate anticipatory guidance.

3) The forms must be signed by the physician performing the exam or supervising the immunizations and screenings. By completing and signing the form, the provider is indicating that the history, physical exam, surveillance, screenings, immunizations, diagnoses, and treatments were performed and are documented in the medical record, as specified on the EPSDT form.

4) The completed and signed EPSDT exam form submitted to a health plan or ACS, by a participating primary care provider for a QUEST or QExA health plan or an active Medicaid provider for FFS respectively, fulfills the State's auditing requirement for compliance with an EPSDT comprehensive periodic screening visit.

5) The form may be copied or printed and used to supplement, but not substitute for, the medical record. However, there should be sufficient documentation in the medical record to support completion of the requirements for a comprehensive EPSDT exam. Results of screening tests and record of immunizations reported on DHS 8015/8016 as being performed must be kept in the medical record.

6) The EPSDT exam is a comprehensive exam and viewed as a global service. Therefore, the treatment of any medical conditions discovered during the EPSDT exam is included in the exam.

7) Care coordination assistance will be provided by the appropriate health plans for QUEST or QExA members and by Community Case Management Corporation (CCMC) for any Medicaid client requiring dental services. The health plans will call the providers and the client/family to coordinate the assistance that is identified. Phone numbers for the health plans and for CCMC are also listed on DHS 8015/8016.

SECTION C: EPSDT Billing Procedures

The enhanced reimbursement ($120 for FFS in 2009*) **for comprehensive EPSDT exams** will apply under the following conditions:

1. Submission of a completed DHS **8015**

a. Attach the original completed and signed hard-copy DHS **8015** to the CMS 1500 claim, and mail to the appropriate health plan for QUEST or QExA members or to ACS for FFS clients. If the completed form is not attached to the claim, the claim cannot be processed as a comprehensive EPSDT visit; or
b. Submit electronically a completed and signed/finalized EPSDT exam through the EPSDT online tool prior to electronic submission of the claim. The health plans or MQD will match the completed electronic EPSDT form with the electronic claim.
c. Without a completed EPSDT form submitted in either hard-copy or electronic as described above, the claim cannot be processed as a comprehensive EPSDT exam and enhanced reimbursement will not be provided.

2. No other claim for an evaluation and management (E&M) service (99201-99255; 99304-99499) is submitted on the same day by the same provider for that patient. The EPSDT exam includes the diagnosis of abnormal conditions and appropriate treatment rendered by the EPSDT examining provider on the day of the EPSDT examination. For example, otitis media found during an EPSDT exam should be submitted with the appropriate EPSDT code; a separate claim line for an office visit for the diagnosis and treatment of otitis medica should NOT be submitted.

3. An eligible code listed in **APPENDIX 1** is used.

The enhanced reimbursement ($30 for FFS in 2009*) **for EPSDT catch-up/follow-up immunizations and screenings** will apply under the following conditions:

1. Submission of a completed DHS **8016**
   a. Attach the original completed and signed hard-copy DHS **8016** to the CMS 1500 claim, and mail to the appropriate health plan for QUEST or QExA members or to ACS for FFS clients. If the completed form is not attached to the claim, the claim cannot be processed as a comprehensive EPSDT visit; or
   b. Submit electronically a completed and signed/finalized EPSDT exam through the EPSDT online tool prior to electronic submission of the claim. The health plans or MQD will match the completed electronic EPSDT form with the electronic claim.
   c. Without a completed EPSDT form submitted in either hard-copy or electronic as described above, the claim cannot be processed as a comprehensive EPSDT exam and enhanced reimbursement will not be provided.

2. No more than two (2) follow-up visits for screening attempts will be reimbursed. For example, if on the dates of the first and second follow-up visit for an audiogram, the child was unable to comply, the provider should note this on the DHS 8016 forms and the visits will be reimbursed. However, if the child is unable to comply after the second visit, the provider should not schedule a third catch-up/follow-up visit. Instead, the audiogram should be attempted at the next EPSDT comprehensive visit.

3. An eligible code in **APPENDIX 2** is used.

APPENDIX 1: BILLING CODES FOR COMPREHENSIVE EPSDT EXAMS

Code	Modifier	Brief Description	Usage
New Patient			
99381	EP	Initial comprehensive preventive medicine E&M; infant less than 1 year of age	Initial EPSDT exam for a well infant, an infant with an acute illness, or an infant who is a child with special health care needs (CSHCN); less than 1 year of age. No other E&M can be billed for the same date of service.
99382	EP	Initial comprehensive preventive medicine E&M; age 1 through 4	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 1 through 4. No other E&M service can be billed for the same date of service.
99383	EP	Initial comprehensive preventive medicine E&M; age 5 through 11	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 5 through 11. No other E&M service can be billed for the same date of service.
99384	EP	Initial comprehensive preventive medicine E&M; age 12 through 17	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 12 through 17. No other E&M service can be billed for the same date of service.
99385	EP	Initial comprehensive preventive medicine E&M; age 18 through 20	Initial EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 18 through 20. No other E&M service can be billed for the same date of service.
Established Patient			
99391	EP	Periodic comprehensive preventive medicine E&M; infant less than 1 year of age	Periodic EPSDT exam for a well infant, an infant with an acute illness, or an infant who is a CSHCN; less than 1 year of age. No other E&M service can be billed for the same date of service.
99392	EP	Periodic comprehensive preventive medicine E&M; age 1 through 4	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 1 through 4. No other E&M service can be billed for the same date of service.
99393	EP	Periodic comprehensive preventive medicine E&M; age 5-11	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 5 through 11. No other E&M service can be billed for the same date of service.
99394	EP	Periodic comprehensive preventive medicine E&M; age 12-17	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 12 through 17. No other E&M service can be billed for the same date of service.

APPENDIX 1, CONTINUED: BILLING CODES FOR COMPREHENSIVE EPSDT EXAMS

Code	Modifier	Brief Description	Usage
Established Patient			
99395	EP	Periodic comprehensive preventive medicine E&M; age 18-20	Periodic EPSDT exam for a well child, a child with an acute illness, or a CSHCN; age 18 through 20. No other E&M service can be billed for the same date of service.
99232	EP	Subsequent hospital care	Initial or periodic EPSDT exam for infant/child/youth performed during an inpatient acute hospital stay. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.
99308	EP	Subsequent nursing facility care	Initial or periodic EPSDT exam for infant/child/youth performed during a nursing facility stay. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.
99348	EP	Established patient home visit	Initial or periodic EPSDT exam for infant/child/youth performed in the child's home. At the time of evaluation, the infant, child, or youth may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service. The child must be homebound/bedbound for medically appropriate reasons and the physician must be able to provide all age appropriate screening and surveillance in the home setting.
99460	EP	History and examination of a normal newborn infant (formerly code 99431)	Initial EPSDT exam of a normal infant one more or less of age in the hospital or birthing room. At the time of evaluation, the infant may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.
99461	EP	Normal newborn care in other than hospital or birthing room (formerly code 99432)	Initial EPSDT exam of a normal infant one more or less of age in a setting other than the hospital or birthing room. At the time of evaluation, the infant may be well, have an acute illness, or be a CSHCN. No other E&M service can be billed for the same date of service.

APPENDIX 2: BILLING CODES FOR CATCH-UP/FOLLOW-UP EPSDT EXAMS

Code	Modifier	Brief Description	Usage
99211	EP	Established patient, office or outpatient evaluation and management that may not require the presence of a physician.	Immunization catch-up, repeat screening(s), and/or screening(s) not performed during an EPSDT exam visit that do NOT require the presence of a physician.
99212	EP	Established patient, office or outpatient evaluation and management, physician performed.	Immunization catch-up, repeat screening(s), screening(s) not performed during an EPSDT exam visit, follow-up of a referral and/or follow-up on a diagnosis or treatment that require a face to face assessment by the physician.

If an E&M service on a catch-up/follow-up visit requires more than a problem focused history and examination and straightforward decision making, the codes 99213-99215 with an EP modifier should be used. Medical records must justify this level of E&M service. A DHS 8016 must be attached to the claim.

Code	Modifier	FFS Rate as of 2009*
99213	EP	$36.31
99214	EP	$56.46
99215	EP	$83.57

*Reimbursement rates in this memo are specific to the FFS fee schedule as of 2009, which is subject to change. The current fee schedule should always be consulted. Please check with the QUEST and QExA health plans for specific health plan rates.

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) Exam

Please COMPLETELY fill in this form by supplying the requested information and filling in the appropriate O

PATIENT INFORMATION

Screen Date (MMDDYY)	Indicate the EPSDT periodic screening age being reported																					Sex	
	14 d	30 d	2 m	4 m	6 m	9 m	12 m	15 m	18 m	2 y	3 y	4 y	5 y	6 y	8 y	10 y	12 y	14 y	16 y	18 y	20 y	M	F
	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

Name (Last, First, Middle Initial)	Medicaid/QUEST ID	Birthdate (MMDDYY)
	0 0	

MEASUREMENTS

For infants, head circumference and weight for length should be assessed and documented in the Medical record.

Blood Pressure	Height (In)	Weight (Lbs)	BMI #	BMI %	BMI Reference – For Information Only		
/		.			Normal < 85%	Overweight 85%-94%	Obese ≥95%

IMMUNIZATIONS GIVEN TODAY AND STATUS

HepB	O	PCV	O	MMR	O	Tdap	O	**Immunization(s) Not Given**
DTaP	O	Rotav	O	Varicella	O	MCV4/MPSV4	O	Immunizations up to date O
IPV	O	Influenza	O	HepA	O	HPV	O	Catch Up Scheduled O
Hib	O	Other (List)					O	Refused (List) O
Comments:								Contraindicated (List) O

SCREENING DONE TODAY

		Normal	Abnormal
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y		O	O
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y		O	O
Developmental Screening *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)	PEDS: ≥ 2 predictive concerns = Abnormal ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal Other (list)	O	O
Autism Screening *(see back) 18m, 24m Fail = Abnormal	CHAT M-CHAT Other (list)	O	O

	Done
Blood Lead Level 9 - 12m, 2y (2 levels required by 2 years)	O
Hgb/Hct 9m – 12m, Females-12y – 14y	O
Comments for screenings not done:	

	Y	N
Has the child seen a dentist within the past year?	O	O

As part of surveillance per the AAP/Bright Futures recommended periodicity (see back), the following should be done and documented in the medical record: TB risk assessments, lead risk assessment, psychosocial/behavioral assessments, and for adolescents- alcohol/drug use assessment, and as appropriate - dyslipidemia, STI, and cervical dysplasia screening.

REFERRALS MADE TODAY

By leaving this section blank, I am confirming that there are no referral needs.

Already referred or receiving state or specialty services.	O	H-KISS	O	PHN	O	CAMHD	O	WIC	O		
Patient/parent refused.	O	PT/OT/Speech/Audiology	O	DOE	O	DDD	O	Child Welfare	O	Dentistry	O
Behavioral Health/Substance Abuse (List name & specialty)			O	Nutrition/Exercise (List name & specialty)							O
Medical/Surgical/Developmental (List name & specialty)			O	Other(s) (List name & specialty)							O

CARE COORDINATION ASSISTANCE NEEDED

Please call patient's Health Plan for Care Coordination assistance if needed.

No Care Coordination Needed	O	Managing medical condition and/or medications	O	Obtaining foreign/sign language translation	O	Obtaining dental care (If yes, call CCMC)	O	Scheduling/Keeping appointments	O		
Arranging transportation	O	Coordinating multiple appointments	O	Family needs assistance in following the POC	O	Obtaining specialty services	O	Other	O		
If assistance is needed, please provide parent's/ caregiver's telephone no. The health plan will call to facilitate coordination.				List additional information or other assistance needed:							
.											

Phone Numbers						
	Alpha Care	808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)	Kaiser QUEST	808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)	CCMC Dental Resource	808-486-8030 (Oahu) 1-866-486-8030 (Toll Free)
	HMSA QUEST	808-948-6486 (Oahu) 1-800-440-0640 (Toll Free)	Ohana Health Plan	1-888-816-4262	Evercare	1-888-980-8726

PROVIDER STATEMENT: A complete EPSDT exam also includes a history (initial or interval), a physical exam, age appropriate surveillance and anticipatory guidance. By signing below, I confirm that these were performed and documented in the patient's medical record.

Provider Name (Print)	Signature	NPI #

For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).

GENERAL INSTRUCTIONS FOR DHS 8015
Submit this form with your CMS 1500 claim form.

The following instructions detailing the completion of the Hawaii EPSDT DHS 8015 form can also be found on the Med-QUEST Division's website, www.med-quest.us, and in the Hawaii State Medicaid Provider Manual.

Complete the form using either **black** or **blue** ink. When indicated, fill in circles. **Do not (√) check, (x) cross, or (/) line through the circles.**

Section: Patient Information
1. Fill in date of screening visit (date should match date of service on CMS 1500 Claim form)
2. If the age of the patient on the date of the exam is **NOT** at the specific age listed in the column, indicate the EPSDT periodic screening age being reported. Usually, this is the age range immediately below the age of the child. E.g. If the child is 8 months and the child has not had a 6 month EPSDT exam, select 6 months. If the child is 8 months and has had a 6 month exam, an interperiodic exam can be done, with a 9 month EPSDT exam scheduled for a later date. If the child is 8 months but almost 9 months, and has had a 6 month exam, a 9 month EPSDT exam can be selected with subsequent visits prior to the 12 month visit billed as interperiodic exams.

Section: Measurements
1. Record height and weight in English using pounds and inches.
2. Calculate BMI and BMI% for children age **2 – 20 y/o**, using the CDC website BMI calculator (http://apps.nccd.cdc.gov/dnpabmi/).

Section: Immunizations Given Today
1. Fill in the circle(s) next to all of the immunizations given at visit. Indicate if immunizations are up to date, if catch-up is scheduled, if immunizations were refused, or if immunizations were contraindicated. This section should **NOT** be left blank.

Section: Screening Done Today
1. Record the results of the vision screening by filling in the appropriate circle. Use one or more of the listed validated vision screening tools.
2. Record the results of the audiometry testing by filling in the appropriate circle. A diagnostic audiologic assessment should also follow any positive hearing screens of newborns and children less than 4 years.
3. Record the results of the developmental screening, if done, by filling in the appropriate circle. It is recommended that either the PEDS or ASQ screening tool be used. Another validated screening tool recommended by the AAP may be used. A list of these may be found in the latest AAP policy on 'Identifying Infants and Young Children with Developmental Disorders in the Medical Home' (Table 1- General Developmental Screening Tools) that can be accessed through http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405
4. Record the results of the autism screening, if done, by filling in the appropriate circle. It is recommended that either the CHAT or M-CHAT screening tool be used. Another validated screening tool recommended by the AAP may be used. A list of these may be found in the latest AAP policy on 'Identifying Infants and Young Children with Developmental Disorders in the Medical Home' (Table 1- Autism Screening Tools) that can be accessed through http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405
5. Fill in the circle if a blood lead level was ordered. Blood lead levels are required at 9 – 12 months and 2 years of age. A blood lead level should be done at 3 – 6 years of age if a level has never been done or risk level changes.
6. Fill in the circle if an Hgb/Hct blood level was ordered. Follow EPSDT's recommended age(s) as listed.
7. Indicate if the child has seen a dentist. Y or N should be selected.
8. If no screenings were done, leave the section blank.

Section: Referrals Made Today (Leave the section black if no referrals were made during this visit)
1. Fill in the appropriate circle(s).
2. List the program(s) and/or specialty(ies) as indicated. For medical/developmental specialties, please note the specialty and agency or individual to whom the referral was made.
3. If referrals are made, please list a current phone number for parental contact under the Care Coordination section, so that the health plan can follow-up on the referral.

**Note: If specific services or programs are not known, refer patient to H-KISS, a DOH central referral agency for developmental early intervention services. If child is school age, refer to DOE. A referral may be made even prior to establishing a diagnosis.

Section: Care Coordination Assistance Needed
1. Fill in the appropriate circle(s) next to the assistance needed for the patient. If no care coordination is needed, indicate this by selecting 'no care coordination needed'.
2. Record the patient's/parent's/caregiver's contact phone number if assistance is needed. Refer patient/parent/caregiver to appropriate Health Plan if preferred.

Section: Provider Statement
1. To be considered complete, the provider signature **MUST** be filled out along with the provider's NPI #.

Surveillance, risk assessment, and anticipatory guidance should follow the AAP/Bright Futures recommended periodicity schedule and guidelines.
The AAP/Bright Futures periodicity schedule and guidelines can be found at http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html

Tuberculin Skin Test (TST) Risk Assessment & Recommendations for Infants, Children, and Adolescents (http://aapredbook.aappublications.org)
(Bacille Calmette-Gue´rin immunization is not a contraindication to a TST.) (HIV = Human Immunodeficiency Virus; LTBI = Latent Tuberculosis Infection)
Children for whom immediate TST is indicated (Beginning as early as 3 months of age):
- Contacts of people with confirmed or suspected contagious tuberculosis (contact investigation)
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from countries with endemic infection (eg, Asia, Middle East, Africa, Latin America, countries of the former Soviet Union) including international adoptees
- Children with travel histories to countries with endemic infection and substantial contact with indigenous people from such countries (If the child is well, the TST should be delayed for up to 10 weeks after return.)

Children who should have annual TST:
- Children infected with HIV
- Incarcerated adolescents

Children at increased risk of progression of LTBI to tuberculosis disease: Children with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these people are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of tumor necrosis factor-alpha antagonists, or immunosuppressive therapy in any child requiring these treatments.

Hawaii Early And Periodic, Screening, Diagnosis, and Treatment (EPSDT) IMMUNIZATION CATCH UP & FOLLOW-UP FORM

Please fill in this form by supplying the requested information and filling in the appropriate O for the areas covered by today's visit

The DHS 8016 form should be used to document the completion of any screening(s) and/or immunization(s) that were attempted and not done during a comprehensive EPSDT Screening visit (8015 document). In addition, the 8016 must be used to document any immunization or screening not captured on the 8015, or not associated with a comprehensive EPSDT screening visit.

PATIENT INFORMATION

Screen Date (MMDDYY)	Name (Last, First, Middle Initial)

Medicaid/QUEST ID	Birthdate (MMDDYY)	Sex
0 0		M O F O

IMMUNIZATIONS GIVEN TODAY AND STATUS

HepB	O	PCV	O	MMR	O	Tdap	O	DTaP	O	Rotav	O	Varicella	O	MCV4/MPSV4	O		
IPV	O	Influenza	O	HepA	O	HPV	O	Hib	O	Other (List)						O	

Comments:

SCREENING DONE TODAY

		Normal	Abnormal
Vision Screening: Snellen, Allen, Tumbling Es, LEA Symbols 3y, 4y, 5y, 6y, 8y, 10y, 12y, 14y-16y, 18y		O	O
Hearing Screening: Audiometry (20-25 db screen) 4y, 5y, 6y, 8y, 10y		O	O
Dev: PEDS/ASQ *(see back) 9m, 18m, 24m - 36m (3 screenings required by 36 months)	PEDS: ≥ 2 predictive concerns = Abnormal ASQ: ≥ 1 domain falling below normal cut-offs = Abnormal Other (list)	O	O
Autism: CHAT, M-CHAT *(see back) 18m, 24m	Fail = Abnormal Other (list)	O	O

REFERRALS MADE TODAY

By leaving this section blank, I am confirming that there are no referral needs.

Already referred or receiving state or specialty services.	O	H-KISS	O	PHN		O	CAMHD	O	WIC	O					
Patient/parent refused.	O	PT/OT/Speech/Audiology	O	DOE	O	DDD	O	Child Welfare	O	Dentistry	O				
Behavioral Health/Substance Abuse (List)			O	Nutrition/Exercise (List)							O				
Medical/Surgical/Developmental (List)			O	Other(s) (List)							O				

CARE COORDINATION ASSISTANCE NEEDED

Please call patient's Health Plan for Care Coordination assistance if needed.

Phone Numbers						
	Aloha Care	808-973-1650 (Oahu) 1-800-434-1002 (Toll Free)	Kaiser QUEST	808-432-5330 (Oahu) 1-800-651-2237 (Toll Free)	CCMC Dental Resource	808-486-8030 (Oahu) 1-866-486-8030 (Toll Free)
	HMSA QUEST	808-948-6486 (Oahu) 1-800-440-0540 (Toll Free)	Ohana Health Plan	1-888-846-4262	Evercare	1-888-930-8726

Comments:

Provider Name (Print)	Signature	NPI #

For additional forms, contact ACS at 808-952-5570 (Oahu) or 800-235-4378 (Toll Free).

GENERAL INSTRUCTIONS FOR DHS 8016
Submit this form with your CMS 1500 claim form.

The following instructions detailing the completion of the Hawaii EPSDT DHS 8016 form can also be found on the Med-QUEST Division's website, www.med-quest.us, and in the Hawaii State Medicaid Provider Manual.

This form is designed to be used by providers to enter immunization(s), screening(s), and/or referral(s) that was/were attempted or not done on during a previous comprehensive EPSDT screening visit and/or not entered onto the EPSDT DHS form 8015. In addition, the EPSDT DHS 8016 form **MUST** be used to document any immunization or screening not captured on the EPSDT DHS 8015 form, or not associated with a comprehensive EPSDT screening visit. Information should be completed only for those sections that were completed during this catch-up EPSDT visit.

Complete the form using either **black** or **blue** ink. When indicated, fill in circles. **Do not (√) check, (x) cross, or (/) line through the circles.**

Section: Patient Information
1. Fill in date of screening visit (date should match date of service on CMS 1500 Claim form)

Section: Immunizations Given Today (Leave the section black if no immunizations were given during this visit)
1. Fill in the circle(s) next to all of the immunizations given at visit.

Section: Screening Done Today
1. Record the results of the vision screening by filling in the appropriate circle. Use one or more of the listed validated vision screening tools.
2. Record the results of the audiometry testing by filling in the appropriate circle. A diagnostic audiologic assessment should also follow any positive hearing screens of newborns and children less than 4 years.
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5. If no screenings were done, leave the section blank.

Section: Referrals Made Today (Leave the section black if no referrals were made during this visit)
1. Fill in the appropriate circle(s).
2. List the program(s) and/or specialty(ies) as indicated. For medical/developmental specialties, please note the specialty and agency or individual to whom the referral was made.
3. If referrals are made, please list a current phone number for parental contact under the Care Coordination section, so that the health plan can follow-up on the referral.

**Note: If specific services or programs are not known, refer patient to H-KISS, a DOH central referral agency for developmental early intervention services. If child is school age, refer to DOE. A referral may be made even prior to establishing a diagnosis.

Section: Provider Statement
1. To be considered complete, the provider signature **MUST** be filled out along with the provider's NPI #.

Surveillance, risk assessment, and anticipatory guidance should follow the AAP/Bright Futures recommended periodicity schedule and guidelines.
The AAP/Bright Futures periodicity schedule and guidelines can be found at http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html

Tuberculin Skin Test (TST) Risk Assessment & Recommendations for Infants, Children, and Adolescents (http://aapredbook.aappublications.org)
(Bacille Calmette-Gue´rin immunization is not a contraindication to a TST.) (HIV = Human Immunodeficiency Virus; LTBI = Latent Tuberculosis Infection)
Children for whom immediate TST is indicated (Beginning as early as 3 months of age):
- Contacts of people with confirmed or suspected contagious tuberculosis (contact investigation)
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from countries with endemic infection (eg, Asia, Middle East, Africa, Latin America, countries of the former Soviet Union) including international adoptees
- Children with travel histories to countries with endemic infection and substantial contact with indigenous people from such countries (If the child is well, the TST should be delayed for up to 10 weeks after return.)

Children who should have annual TST:
- Children infected with HIV
- Incarcerated adolescents

Children at increased risk of progression of LTBI to tuberculosis disease: Children with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these people are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy, including prolonged steroid administration, use of tumor necrosis factor-alpha antagonists, or immunosuppressive therapy in any child requiring these treatments.

State of Hawaii
Department of Human Services
Med-QUEST Division

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Periodic Screening Guidelines

ELEMENTS OF REQUIRED HEALTH SCREENING	INFANCY							EARLY CHILDHOOD					LATE CHILDHOOD					ADOLESCENCE			
AGE	1-14 DAYS	1-15 DAYS	2 MOS	4 MOS	6 MOS	9 MOS	12 MOS	15 MOS	18 MOS	2 YRS	3 YRS	4 YRS	5 YRS	6 YRS	8 YRS	10 YRS	12 YRS	14 YRS	16 YRS	18 YRS	20 YRS
HISTORY																					
Initial/Interval																					
MEASUREMENTS																					
Length/Height and Weight																					
Head Circumference																					
Weight for Length																					
Body Mass Index																					
Blood Pressure																					
SENSORY SCREENING																					
Vision																		14-16 yrs			
Hearing/Language																					
Audiogram																					
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																					
Developmental Screening																					
Autism Screening																					
Developmental Surveillance																					
Psychosocial/Behavioral Assessment																					
Alcohol and Drug Use Assessment																					
PHYSICAL EXAMINATION																					
PROCEDURES																					
Newborn Metabolic/Hemoglobin Screening																					
Immunization																					
Hematocrit or Hemoglobin						9-12 mos											females				
Lead Risk Assessment																					
Blood Lead Level Screening						9-12 mos															
Tuberculin Skin Test																					
Dyslipidemia Screening																				18-20 yrs	
STI Screening																					
Cervical Dysplasia Screening																					
ORAL HEALTH																					
ANTICIPATORY GUIDANCE																					

Required components to be performed for the age group

Risk Assessment to be performed, with appropriate action to follow, if positive

Appendix J

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

June 7, 2010

MEMORANDUM

ACS/QUEST/QExA MEMO NOS.
ACS M10-04
ADM-1009
ADMX-1009

TO: Acute Care Hospitals
QUEST Health Plans
QExA Health Plans

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: TRANSITION OF CARE – CLARIFICATION ON FINANCIAL RESPONSIBILITY ROLES

The Med-QUEST Division (MQD) is providing the following table to clarify financial responsibilities of MQD programs [QUEST, QUEST Expanded Access (QExA) and fee-for-service (FFS)] concerning transition of care relating to hospital, professional, and enabling services.

If you have any question(s), please contact Patti Bazin at 692-8083 or via e-mail at pbazin@medicaid.dhs.state.hi.us.

Attachment

TRANSITION OF CARE

PURPOSE:

To clarify financial responsibility roles of QUEST Health Plans, QUEST Expanded Access (QExA) Health Plans, and (MQD) Fee-For-Service (FFS) relating to hospital (H), professional (P), and enabling services (E).

DEFINITIONS:

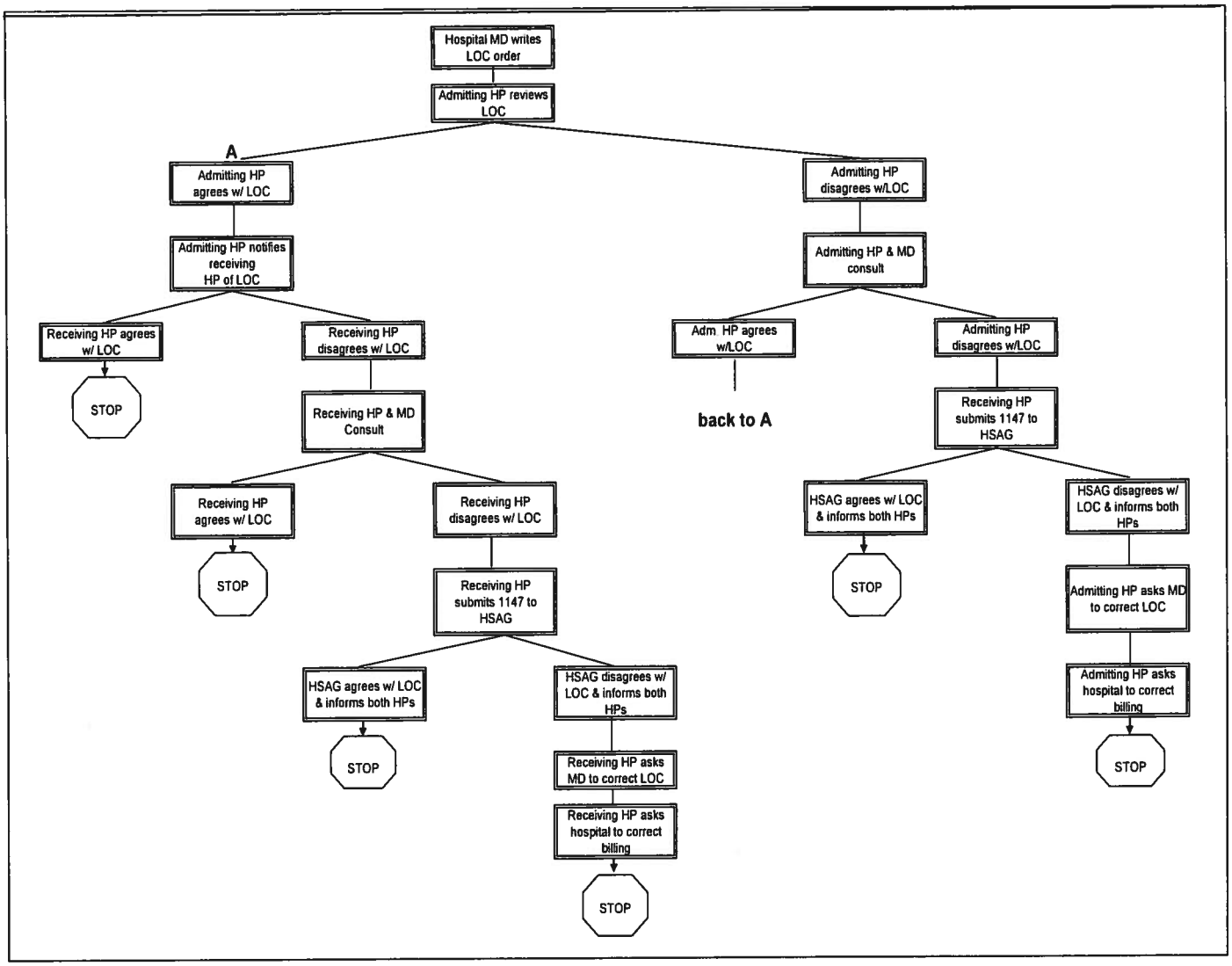
Hospital Services: Hospital services include medically necessary services for registered bed patients that are generally and customarily provided by licensed acute care general hospitals in the service area and prescribed, directed or authorized by the attending physician or other provider.
Professional Services: Professional services include services provided by physicians and any other outpatient hospital services. Examples may include medical supplies, equipment and drugs; diagnostic services; and therapeutic services including chemotherapy and radiation therapy.
Enabling Services: Enabling services include transportation (air or ground), lodging, meals, attendant/escort care, and any other services that may be needed.
Fee for Service (FFS) Window: The period of time after which a client is accepted into QUEST and before he/she is enrolled in a QUEST health plan is the FFS window. Also, any client who has less than one-month eligibility will be in FFS.
Transfer: A transfer to another facility (whether in state or out of state) is equivalent to a discharge from the original facility.
Level of Care Change: The first change from acute to less than acute level of care (sub-acute, waitlisted sub-acute, SNF, waitlisted SNF, ICF, waitlisted ICF).

The following rules apply in determining which entity (FFS, QUEST health plan, or QExA health plan) is responsible:

- **Eligibility for long-term care services and enrollment into managed care health plans** can be retroactively applied a maximum of 90 days from the date of application.
- **The FFS window applies only for QUEST**, not QExA. However, if a client deemed aged, blind, or disabled has less than one-month eligibility, he/she will be in FFS.
- **For QExA health plans, there is not a FFS window**. A QExA health plan is responsible for the client as soon as the client becomes eligible, which becomes the first day of enrollment in that health plan.
- **For acute inpatient hospitalizations**, the admitting health plan is responsible for hospital services from admission to discharge or to change in level of care, whichever comes first.
- **For professional services,** the health plan into which a client is enrolled on the date(s) the service was rendered is responsible, even if the client is in an acute inpatient hospital and enrollment is retroactively applied.
- **For enabling services,** the health plan into which a client is enrolled on the date(s) the service was rendered is responsible, including transportation, meals, lodging, and attendant care.
- **For clients sent out-of-state by the original health plan,** the original health plan is responsible for hospitalization from admission to change in level of care. The original health plan is also responsible for the transportation to get the client and attendant, if applicable, to the out-of-state services. If round trip tickets were purchased, the original health plan may bill the new responsible party for the return trip of the client and the client's attendant, if applicable. Otherwise, the health plan into which the client is enrolled becomes responsible for enabling services, including transportation, meals, and lodging. As round trip air fare is less costly than one-way fare, the health plans involved may share the cost of a round trip fare, rather than purchase one-way fares.
- **State of Hawaii Organ and Tissue Transplant (SHOTT) Program** covers clients approved as candidates by MQD for liver, lung, heart, small bowel, and kidney transplants (if Medicare does not cover the kidney transplant). The client will be disenrolled from QUEST, QExA, and FFS on the date of MQD approval and covered under the SHOTT program until at least one year post transplant.

LEVEL OF CARE RULES:

A level of care change is defined for the purposes of this memo as **the first change from acute to less than acute** level of care (sub-acute, waitlisted sub-acute, SNF, waitlisted SNF, ICF, waitlisted ICF). See attached flow chart for details.



H=hospital, P=professional services, E=enabling services, LOC=level of care, OOS=out of state

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
Acute Inpatient				
1) QUEST health plan from admission to discharge.	Covers H, P, and E from admission to discharge.			
2) QExA health plan from admission to discharge.		Covers H, P, and E from admission to discharge.		
3) FFS admission to discharge.			Covers H, P, and E from admission to discharge.	
4) One QUEST health plan on admission switches to another QUEST health plan after admission.	Admitting QUEST health plan covers H until LOC change and covers P and E once enrolled in the receiving QUEST health plan. Receiving QUEST health plan picks up H after LOC change and covers P and E once enrolled into the receiving health plan.			If the LOC remains acute for the entire hospitalization, the admitting QUEST health plan is responsible for H from admission to discharge.
5) One QExA health plan on admission switches to another QExA health plan after admission.		Admitting QExA health plan covers H until LOC change and covers P and E until enrolled in the receiving QExA health plan. Receiving QExA health plan picks up H after LOC change and covers P and E once enrolled into the receiving health plan.		If the LOC remains acute for the entire hospitalization, the admitting QExA health plan is responsible for H from admission to discharge.
6) QUEST health plan on admission. Break in coverage. FFS window to discharge.	Covers H, P, and E until eligibility ends.		Covers H, P, and E during FFS window.	If there is a break in QUEST health plan coverage and the client becomes eligible again, the client will enter the FFS window. If the LOC remains acute, FFS will be responsible from the

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
				date QUEST health plan eligibility ends.
7) *QUEST health plan on admission. Change to QExA health plan after admission.*	Covers H until LOC change. Covers P and E until enrolled in a QExA health plan.	Covers P and E once enrolled in the QExA health plan. Covers H after LOC change.		If the LOC remains acute for the entire hospitalization, the admitting QUEST health plan is responsible for H from admission to discharge.
8) *FFS on admission. Change to QUEST health plan during admission.*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change.		Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	The FFS window applies to QUEST. If the LOC remains acute for the entire hospitalization, FFS is responsible for H from admission to discharge.
9) *FFS on admission. Change to QUEST health plan during admission. Client on SNF/ICF waitlist for 60 days. Change to QExA health plan at 61st day.*	Covers P and E once enrolled in the QUEST health plan. Covers H from LOC change through the 60th day of an SNF/ICF waitlist.	Covers H, P, and E once enrolled in the QExA health plan on the 61st day of waitlist.	Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	The FFS window applies to QUEST.
10) *FFS on admission. Waitlisted SNF level of care while on FFS. Change to QUEST health plan.*	Covers P and E once enrolled in the QUEST health plan.		Covers H to discharge. Covers P and E until enrolled in a QUEST health plan.	
11) *FFS on admission. Change to QUEST health plan during admission. Patient goes through ADRC. Change to QExA health plan as per ADRC determination (1st day of the second month following receipt of completed ADRC packet).*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change if this occurs during QUEST health plan.	Covers P and E once enrolled in the QExA health plan (on the 1st day of the second month following receipt of completed ADRC packet). Covers H after LOC change if this occurs during QExA health plan.	Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	The FFS window applies to QUEST. If the LOC change occurs during FFS prior to change to a QUEST health plan or a QExA health plan, FFS would be responsible for H until discharge.

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
12) *FFS on admission. Retroactive change to QExA health plan during admission.*		Covers H, P, and E from admission to discharge.		There is no FFS window in QExA.
13) *QExA health plan on admission. Eligibility lapses. FFS window. QUEST health plan before discharge and still QUEST health plan on discharge.*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change.	Covers H, P, and E until eligibility ends.	Covers H, P, and E during FFS window prior to enrollment in a QUEST health plan. Continues to cover H until LOC change.	If the LOC remains acute for the entire hospitalization, QExA health plan is only responsible for H until the day eligibility ends. FFS is responsible for H from the date QExA health plan enrollment ends until discharge.
Transfer from acute to acute hospital in state				
14) *QUEST health plan on admission to first facility. QExA health plan before transfer/discharge to the second facility.*	Covers H during first hospitalization until transfer/discharge to second facility. Covers P and E until enrolled in a QExA health plan.	Covers P and E once enrolled in the QExA health plan during the first hospitalization. Responsible for transfer/transportation to the second facility. Covers H, P, and E at second hospital.		Transfer = discharge.
15) *QUEST health plan on admission to first facility. Break in eligibility. FFS window before transfer and during stay at second facility.*	Covers H during first hospitalization until eligibility ends. Covers P and E until eligibility ends.		Covers H, P, and E during FFS window. Responsible for transfer/transportation to the second facility. Covers H, P, and E at second hospital.	
Out of state (OOS) services				
16) *QUEST health plan authorizes OOS hospital services. Changes to QExA health plan during OOS hospital stay.*	Covers H until LOC change at OOS hospital. Covers P and E until enrolled in a QExA health plan.	Covers P and E once enrolled in the QExA health plan. Covers H after LOC change at OOS hospital.		If the QUEST health plan has round trip ticket(s), the QUEST health plan may bill the QExA health plan for the return ticket(s).

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
17) *QUEST health plan authorizes OOS services. QUEST health plan during initial hospitalization through discharge from the hospital. Transfer to QExA health plan after discharge from the hospital while OOS (outpatient services, additional hospitalization).*	Covers H, P, and E for initial hospitalization.	Covers H, P, and E for additional hospitalizations. Covers P and E for outpatient services.		If QUEST health plan has round trip ticket(s), QUEST health plan may bill the QExA health plan for the return ticket(s).
18) *FFS authorizes OOS services. QUEST health plan before discharge.*	Covers P and E once enrolled in the QUEST health plan. Covers H after LOC change.		Covers H until LOC change. Covers P and E until enrolled in a QUEST health plan.	If FFS has round trip ticket(s), FFS may bill the QUEST health plan for the return ticket(s).
19) *FFS authorizes OOS services. QExA health plan before discharge.*		Covers H, P, and E once enrolled in the QExA health plan.		There is no FFS window in QExA. If FFS has round trip ticket(s) purchased prior to QExA implementation, FFS may bill QExA health plan for cost of return ticket(s).
Outpatient hospital, rehab and other services in state				
20) *QUEST health plan authorizes outpatient services. QExA health plan at the time of services.*		QExA health plan honors QUEST health plan's authorization for thirty (30) days or until an assessment is completed. Covers H, P, and E once enrolled in the QExA health plan.		
21) *QExA health plan authorizes services. Break in coverage. FFS at time of services.*			FFS honors QExA health plan's authorization. Covers H, P, and E once enrolled in FFS.	

Insurance Coverage Scenario	QUEST Responsibility	QExA Responsibility	FFS Responsibility	Comments
22) Dental Services authorized by Cyrca. Client QUEST health plan, QExA health plan, or FFS at the time of the services.	Covers H and P for hospital and anesthesia.	Covers H and P for hospital and anesthesia.	Covers H and P for hospital and anesthesia.	Dental services covered by Cyrca Dental. Anesthesiologist and hospital covered by the health plan effective at the time of procedure. Enabling services covered by Cyrca Dental.
SHOTT				
23) QUEST health plan, QExA health plan, or FFS on admission. SHOTT before discharge and transplant.	Covers H, P and E until enrolled into SHOTT	Covers H, P and E until enrolled into SHOTT.	Covers H, P and E until enrolled into SHOTT.	SHOTT covers H, P, E once enrolled into the SHOTT program.
24) SHOTT on admission. Eligibility for SHOTT terminates during admission and enrolled in QUEST health plan, QExA health plan, or FFS.	Covers P and E once enrolled in the QUEST health plan. Picks up H after LOC change.	Covers P and E once enrolled in the QExA health plan. Picks up H after LOC change.	Covers P and E once enrolled in FFS. Picks up H after LOC change.	SHOTT covers H from admission to LOC change. Client is disenrolled from SHOTT and enrolled into QUEST health plan, QExA health plan, or FFS on the 1st of the following month.